State of Oklahoma

1115(a) Research and Demonstration Waiver

Submitted by

Oklahoma Health Care Authority

in collaboration with

Oklahoma State Department of Health

Department of Human Services and

Oklahoma State Medical Association

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Preface

The State of Oklahoma, under the authority of 42 U.S.C. §1115(a) of the Social Security Act, is requesting a five-year Research and Demonstration Waiver to expand Medicaid eligibility for reproductive health benefits to Oklahoma women, men, and couples with incomes at-or-below one-hundred-eighty-five percent (185%) of the Federal Poverty Level (FPL). Without this waiver, these individuals would otherwise be ineligible for reproductive health services under the current Medicaid program. While the State of Oklahoma already operates an approved Research and Demonstration Waiver under §1115(a) of the Social Security Act, it has chosen to seek a separate waiver for this expansion of reproductive health benefits. There are several reasons for submitting separate waivers.

First, the existing ***SoonerCare*** waiver was designed and implemented for the very limited purpose of enabling the State to transition its traditional fee-for-service Medicaid Program to a managed care program, as required under Oklahoma law (63 O.S. § 5009, et seq.). Under the provisions of this statute, and in keeping with the managed care enrollment timetable established in another section of Oklahoma law (56 O.S. § 1010.3), the State, under the direction of the Oklahoma Health Care Authority, continues to systematically transition defined eligible categorical populations into managed care. The criteria for determining eligibility under the two waivers are entirely different. Under the ***SoonerCare*** waiver, all recipients meet the categorical requirements for Medicaid eligibility in the fee-for-service system. The only issue for these recipients is whether they belong to a group that is being transitioned into managed care or if they will remain in the fee-for-service program.

The reproductive health waiver, by comparison, has not been developed to facilitate service delivery through a managed care system. Rather, it has been proposed solely to deliver a comprehensive package of reproductive health services to individuals who are not otherwise eligible for Medicaid. In addition, the providers or provider networks serving recipients under each of the two waivers are not comparable. Since many reproductive health providers do not participate in the managed care program, clients who receive reproductive health services through the reproductive health waiver may not be served through the managed care system.

Second, there exists the likelihood of timeline conflicts. There are statutorily prescribed eligibility expansion time frames that govern the State's operation of the ***SoonerCare*** 1115(a)

waiver that will not exist under the reproductive health waiver, since it is not statutorily established. Because the ***SoonerCare*** 1115(a) waiver's deadlines are mandated, the Oklahoma Health Care Authority's priorities must focus first on meeting these. Based on the agency's current scheduled workload, particularly in the Medical Management Information Services (MMIS) Division, implementation of services under the reproductive health expansion will occur in 2002 or 2003. This would result in the reproductive health waiver beginning two to three years after the extension under the ***SoonerCare*** waiver.

Logistical difficulties would naturally occur if two large, diverse programs began operation at entirely different times under one waiver. In addition, if implementation of the reproductive health waiver followed the patterns usually experienced under implementation waivers, one to two years of increased administrative costs would be incurred in the program's early years. In order to achieve budget neutrality, it would be essential that the remaining waiver period be long enough for these costs to have been offset by cost savings, which would normally increase. However, if the programs were integrated under the existing 1115(a) waiver, it is unlikely that budget neutrality could be achieved, since the waiver's extension period would most likely have ended before any savings were realized. In addition, it is unlikely that savings under the managed care program could be used to offset high start-up costs under the reproductive health waiver, since managed care savings will normally be used to achieve neutrality under the managed care component of the waiver.

Executive Summary

The five-year Research and Demonstration Project, as outlined in this proposal, is known as SoonerPlan Research and Demonstration Project. It is a collaborative effort between the following: 1) the Oklahoma Health Care Authority (OHCA), the State's Medicaid Agency; 2) the Oklahoma State Department of Health (OSDH), the agency that has provided reproductive health services to low-income Oklahomans; 3) the Oklahoma Department of Human Services (ODHS), the agency responsible for determining Medicaid eligibility; 4) the Oklahoma State Medical Association (OSMA), an Association that represents Oklahoma's physicians; and 5) the Governor's Office. The State anticipates project implementation to begin early in 2002 and to enroll newly eligible clients for the entire five-year duration of the project.

In Oklahoma, Medicaid-reimbursed births have increased approximately 20 percent since 1995 and, without intervention, are expected to continue to grow. Moreover, the majority (approximately 50.1%) of recent Medicaid births were reported as unintended. The State contends that, among the target population, having greater access, choices, and information regarding reproductive health services will result in greater fertility control, fewer unintended pregnancies, and reduced pregnancy-related costs. Thus, the State is prepared to explore various strategies, including utilization of providers not previously involved in Medicaid reproductive health services and a model that promotes strengthening couple relationships through shared contraceptive decision-making.

Implementation of the proposed waiver will enable comparisons of various service providers to determine the most effective approach, especially in rural areas, where access barriers are more likely to occur. The proposed waiver will address the following:

- The State believes that blending Title XIX with Title X will provide a greater number of effective reproductive health services to a greater number of people, especially in rural areas. The extended reproductive health benefit package will include a set of benefits funded through Title XIX, plus an enhanced package containing outreach and educational services funded through Title X.
- Among the target population, the State intends to increase utilization of reproductive health services by including males and expanding access to services and outreach

activities, thus increasing effective control of fertility and reducing unintended pregnancies.

- A survey will be administered at client eligibility intake and repeated at periodic reproductive health visits to determine intended levels of fertility, unintended pregnancies and effectiveness of male participation, outreach services and access to other health care. Other potential sources of data include PRAMS, provider surveys, birth records, Medicaid paid claims, Medicaid eligibility records, and Reproductive health Services data.

- Due to the reproductive health focus, as well as other strategies employed during the demonstration, a $29 million reduction in Medicaid expenditures among the target population is projected over the five-year duration of the waiver.

- Approval and implementation of this waiver will benefit the State of Oklahoma, the Federal government and, most importantly, the clients served.

Glossary of Terms

Intended level of fertility	Intended number of children desired *at present time.*
High parity:	For under age 20: 2 or more previous births For age 20 and over: 4 or more previous births
Inadequately spaced births:	Short birth interval, i.e., less than two years apart.
Sexually transmitted diseases (STD):	Any infection, altered immune or inflammatory response transmitted by any form of sexual contact.
Unintended pregnancy:	A pregnancy, which a woman considers either mistimed (desired at a later time) or unwanted at the time of conception.
Women in need (WIN):	Women in need of publicly supported reproductive health services. This is based on estimates of the number of women with incomes below 185 percent FPL of childbearing age who are sexually active; not contraceptively or naturally sterile; and not pregnant or seeking pregnancy.

CHAPTER ONE: INTRODUCTION AND OVERVIEW

INTRODUCTION

In 1995, the State of Oklahoma initiated a proposal to the Health Care Financing Administration (HCFA) to operate ***SoonerCare,*** a statewide Title XIX managed care research and demonstration program. However, while this statewide waiver proposal was essentially comprehensive, it did not cover all populations that could benefit from specific services covered under this waiver. Therefore, the State indicated its intent to work with other State agencies and providers to target programs for future waiver populations, including a reproductive health expansion. During the intervening period, a collaborative interagency effort has been underway whose goal has been to develop the standards and requirements needed to design the Comprehensive Reproductive health Demonstration Project. The project, as outlined in this proposal, is known as ***SoonerPlan***, the Oklahoma Reproductive health Research and Demonstration Project.

Pursuant to this goal, the State of Oklahoma, under the authority of §1115(a) of the Social Security Act, is requesting a five-year Medicaid Research and Demonstration Waiver to expand Medicaid eligibility for comprehensive reproductive health benefits to two distinct groups who have not been eligible for these services at any time in the past:

- Uninsured women, regardless of pregnancy history, whose family incomes fall at or below 185 percent of the Federal Poverty Level (FPL), who are not otherwise eligible for Medicaid benefits, including women who gain eligibility for Title XIX reproductive health services due to a pregnancy but have lost eligibility 60 days postpartum.
- Uninsured men and couples at or below 185 percent FPL, regardless of pregnancy or paternity history.

In Oklahoma, Medicaid-reimbursed births have increased 20 percent since 1995. Without intervention, the numbers of births are expected to continue to grow. Moreover, the majority (approximately 50%) of recent Medicaid births were reported as unintended.[1] The State contends that many pregnancy-related costs would be avoided if more women in need (WIN) of public reproductive health services prevented unintended pregnancies through successful

[1] Pregnancy Risk Assessment Management System 1999.

participation in low-cost reproductive health programs. To achieve this goal, the State is prepared to explore different strategies, including utilization of various types of providers who have not previously been involved in the delivery of reproductive health services and involving couples, rather than women alone, in contraceptive decisions. The State believes it can successfully realize this objective through the proposed reproductive health waiver.

The proposed demonstration project is a collaborative effort between several agencies and a statewide physician association. These include: 1) the Oklahoma Health Care Authority (OHCA), the State's Medicaid Agency; 2) the Oklahoma Department of Human Services (ODHS), the agency responsible for determining Medicaid eligibility; 3) the Oklahoma State Department of Health (OSDH), the agency which has historically provided reproductive health services to low-income populations; 4) the Oklahoma State Medical Association (OSMA), an Association that represents Oklahoma's physicians; and 5) the Governor's Office. Project implementation is anticipated in early 2002. The State intends to enroll newly eligible clients for a one-year period of eligibility, with annual recertification. Data sufficient for informational purposes and interim reports will be collected and disseminated prior to release of final results.

OVERVIEW

Purpose

The State's overall objective regarding reproductive health is twofold. First, the State hopes to reduce unintended births through successful use of reproductive health services, thus reducing Medicaid program costs. Second, through innovative statewide service delivery to a larger population than has previously been served, the State hopes to facilitate studies of effective ways to provide reproductive health services. Little is known, for example, about what constitutes the most effective provision of reproductive health services in Oklahoma, especially in rural areas, where access barriers are more likely to occur. Also, recent emphasis on male involvement in reproductive health decisions has increasingly highlighted the need for more information regarding male partners in reproductive health decisions. In its demonstration, the State will include studies intended to determine whether the involvement of males in reproductive choices successfully reduces the incidence of unwanted or mistimed pregnancies.

The eligibility expansion will include the coordinated use of both Title XIX and Title X dollars to deliver reproductive health services. Expanded Title X services will include enhanced education and outreach activities, while expanded eligibility for Title XIX will facilitate development, implementation, and evaluation of more effective intervention techniques. The

State believes that blending Title XIX with Title X to expand eligibility, outreach, and education services, will provide a greater number of effective reproductive health services to a greater number of people, especially in rural areas. There will be opportunities to coordinate information, share data, and pool resources in order to enhance delivery of services.

Collaborative Agencies

Oklahoma Health Care Authority (OHCA): Title XIX

Effective January 1, 1995, responsibility for administering Oklahoma's Title XIX program was transferred to the Oklahoma Health Care Authority from the Department of Human Services. The Oklahoma Health Care Authority is governed by a seven-member Board and operates under the direction of an Administrator who is responsible for overseeing all activities of the agency, including administration of personnel and budgeted funds, setting agency priorities, developing a strategic plan and carrying out the mission of the OHCA. For example, as noted previously, most of Oklahoma's Medicaid program operates under an 1115(a) managed care waiver. The OHCA negotiates and enters into contracts with various managed care networks/providers to serve the Medicaid population, which requires delineating obligations, terms and conditions, and capitation rates for various categories of clients.

Oklahoma Department of Human Services (ODHS): Eligibility Determination

Eligibility determination for Title XIX services is performed by ODHS under an interagency agreement with OHCA. The Department is responsible for overseeing the streamlined eligibility process and also accepts applications and determines eligibility at its county field offices, handling managed care, as well as fee-for-service clients. At the interview for eligibility determination, caseworkers provide applicants with information describing ***SoonerCare*** and provider/network options.

Oklahoma State Medical Association (OSMA): representing all physicians

The OSMA is the statewide medical and membership association representing all physicians. It works closely with the American Medical Association and other state medical societies, as well as county medical societies, advocating for the needs of patients and physicians. The goal of OSMA is to "assume a more active and visible role in promoting and improving health education."

The OSMA will assist with waiver implementation through the Physicians' Campaign for a Healthier Oklahoma, by providing information and education about the importance of reproductive health and reimbursement options for reproductive health services. The OSDH will work collaboratively with OSMA to increase access to reproductive health services through the private physician network. In addition, the OSMA will work with the OHCA to assure adequate reimbursement for that provider network. The OSMA is committed to its partnership with the OSDH and the OHCA in the implementation of this Medicaid waiver.

Oklahoma State Department of Health (OSDH): Title X

The Oklahoma State Department of Health administers Title V Maternity Services and Title X Reproductive Health Services. In a recent reorganization, all services were placed under the umbrella of the Women's Health Division, Family Health Services. Maternity services are designed to assess, protect, and improve the prenatal and postpartum health of women and their infants, two of Oklahoma's most vulnerable populations. Title V and Title X reproductive health services are designed to provide access to comprehensive reproductive health and health promotion services and supplies, choices between birth control methods, and education/information, all "key" to decision-making, achieving desired family size, and reducing levels of unintended pregnancy.

County health departments in Oklahoma have a long history of providing services to low-income women and children. Currently, public health reproductive health services are delivered through a network of county health departments and contracted independent community clinics, with approximately 105 clinic sites in 72 of 77 counties across the state. Clinics are required to meet medical and funding source standards and guidelines. Services are provided by physicians, physician assistants, and Advance Practice Nurses to the uninsured, the majority of whom are not currently Medicaid-eligible. County health departments, community clinics, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHC's) serve an essential need for delivering health care services throughout the State.

As many other states have done, Oklahoma has moved to convert many health service functions from fee-for-service to managed care, with varying degrees of success. Urban areas, for example, have a greater number of providers and are better suited to fully capitated managed care models, compared to isolated, rural areas. As a result, under this proposed Reproductive Health Research and Demonstration Waiver, the State is interested in testing different delivery

approaches that will make it easier for low-income women and couples to obtain comprehensive reproductive health and health promotion services.

Evaluation

The focus of the evaluation process will be to assess the efficacy of various provider types and the impact(s) of extending reproductive health benefits to populations who are currently not served. Accordingly, ***SoonerPlan*** will address the following types of questions:

- To what extent does expanded coverage of reproductive health services reduce the number of unintended pregnancies for women who are at or below 185 percent of the FPL?
- To what extent does expanding Medicaid eligibility for reproductive health services to 185 percent of FPL assist women and/or families in reaching their desired level of fertility?
- To what extent does expanding Medicaid eligibility for reproductive health services to 185 percent of FPL reduce the number of women who have subsequent mistimed or unwanted pregnancies and/or births?
- What impact will the participation of spouse/partner in expanded reproductive health services have on decreasing the number of subsequent pregnancies and/or births that are mistimed or unwanted?
- Will the project increase the number of women who were enrolled in ***SoonerCare*** for a delivery who will access reproductive health services funded by Medicaid within six months after the birth of their last child?
- Will the project improve client access to reproductive health services through the use of a variety of public and private service providers?
- Will the project result in an increase in number of clients from identified high risk groups who receive reproductive health services, including men and women of childbearing age at or below 185 percent of the FPL?
- Will the demonstration waiver produce a net annual savings in State and Federal Medicaid expenditures through the use of reproductive health serves and the resulting reduction in costs for prenatal and birth related services?

The OHCA and OSDH will assemble much of the data that will be needed by the independent evaluator selected by OHCA. Historical information is available from ODHS. Project lead staff will work closely with the evaluator to oversee the use of various databases and also help coordinate client and provider surveys, as necessary.

Outcomes

The proposed outcome of this waiver is the reduction of unintended births to women ages 19 - 44 who are at or below 185 percent of the FPL, thereby reducing Medicaid expenditures for prenatal, delivery, and infant care among this population. A related outcome is the delivery of more effective fertility control to women and men who receive comprehensive services as described on pages 20 - 23 of this proposal, and accomplished in part, by allowing all types of reproductive health providers to participate in this project. In order to determine intended levels of fertility, a survey will be administered at client eligibility intake and then repeated at periodic reproductive health visits. Survey measures also will include unintended pregnancies, effectiveness of male participation, outreach services, and access to other health care.

Due to the comprehensive reproductive health focus, as well as other strategies to be used during the demonstration, decreases in expenditures due to the provision of reproductive health services to the target population are expected to occur relative to the current higher costs associated with prenatal, birth, newborn, and infant care. For example, in Oklahoma, the average annual Medicaid reproductive health expenditure is projected to be $196 per recipient for FY-2002. By contrast, Medicaid expenditures associated with childbirth are projected to average $8021 per recipient for FY-2002.[2] Thus, the Demonstration Waiver Project proposed is budget neutral, cost efficient, and consistent with the objectives of the Medicaid program.

[2]Rates provided by OHCA for FY 2000.

CHAPTER TWO: BACKGROUND

Oklahoma Characteristics

Oklahoma is a relatively large state, spanning 77 counties and nearly 70,000 square miles in area, with a population density of about 47 persons per square mile. Roughly half the State's 3.4 million population reside in 70 counties designated as rural and half in the remaining 7 urban counties. Oklahoma's rural communities are varied, both in terms of population characteristics and geographic isolation. For example, rural areas include both small towns located in close proximity to one of the major metropolitan areas, as well as very small, isolated, remote communities, such as those found in the panhandle region of the state.

Oklahoma's population growth has increased at a moderate rate since 1980 and is projected to continue to increase through the early part of the 21st century. Also, the modest economic recovery the State experienced since the mid-1980s following the "oil bust" is not expected to change significantly over the next few years. In 1998, Oklahoma ranked 43rd in the nation for earnings, with a per capita income of $21,072; and about 10 percent of the population received Medicaid-reimbursed services.[3]

Medicaid Births

Beginning in the 1980s, Congress enacted a series of laws that significantly expanded Medicaid coverage to low-income, pregnant women. Initially including families with incomes at or below 133 percent of the FPL, coverage was expanded in 1997 to include families with incomes up to and including 185 percent of the FPL. Not surprisingly, as the number of women covered by Medicaid increased, the number of Medicaid births also increased. In CY-1998, for example, Oklahoma births numbered 49,354, of which nearly half (45.6%) were funded, in part or in whole, by Medicaid. That is, an estimated 22,500 Medicaid births occurred in Oklahoma during CY-1998. By comparison, CY-1995 births totaled 45,365, of which an estimated 18,689 births (42%) were Medicaid-reimbursed.[4]

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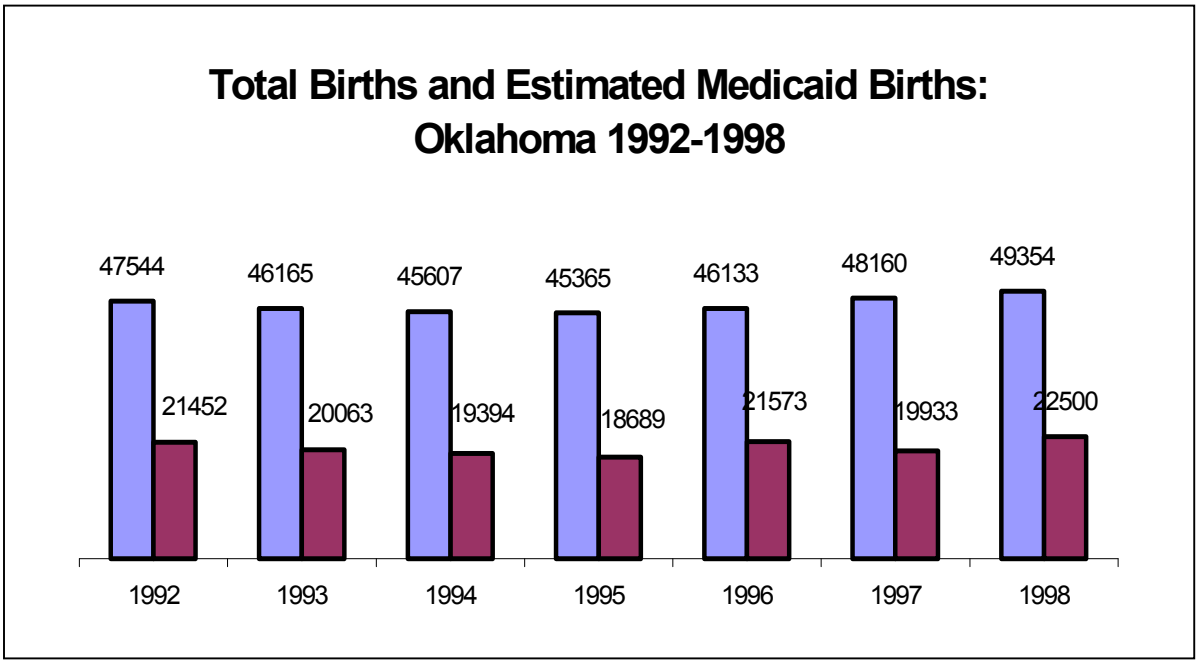
[3] Bureau of Primary Health Care.

[4] OSDH Vital Records and OHCA Medicaid Expenditures.

These figures represent an 8.8 percent increase in the number of overall births in Oklahoma 1995 – 1998 and an estimated increase of over 20 percent of Medicaid births during the same time period. Thus, as overall births in Oklahoma continue to grow, Medicaid births, without intervention, also are expected to increase.



Source: OSDH Vital Records and OHCA Estimated Medicaid Deliveries

Taking into account that Medicaid pays not only for prenatal care and delivery costs for women up to 185 percent FPL, but in most cases, also for first year medical costs for infant care, and additional years of medical costs for disabled infants, decreasing Medicaid funded births translates to potentially significant cost savings at the State and Federal level. Also, potential cost savings related to State and Federal expenditures arises from assistance programs such as Food Stamps, WIC, and TANF.

Oklahoma PRAMS

Since 1987, OSDH has participated in the Pregnancy Risk Assessment Monitoring System (PRAMS) and is in the unique position of having long-term, well-established information regarding unintended pregnancies resulting in live births. For example, according to 1997

PRAMS data, approximately 50 percent of the 48,160 total live births that occurred in Oklahoma that year were reported as unintended at the time of conception (an estimated 24,000 births).[5] It is the State's intent to reduce both the incidence of unintended births among low-income women and the costs associated with them, by extending reproductive health benefits to more women in need.

In Oklahoma, the population of Women in Need (WIN) ages 19 and above who need public reproductive health services, is estimated as 122,744.[6] This estimate is useful in that it provides a standard by which to compare targeted sub-units of the population, such as women living within specific counties or other geographically defined areas. In addition:

- In calendar year 2000, of the 631,285 women in Oklahoma ages 19-44, about 22 percent, or 139,000, have no access to health insurance or Medicaid to pay for health services;[7]
- Nearly all (about 94%) of the women served through OSDH Reproductive health services would have been eligible for Medicaid ***had they become pregnant***; however, only about three percent currently qualify for Medicaid reproductive health benefits because the income thresholds used to determine eligibility are low (130% of FPL);
- In fiscal year 2000, Title X reproductive health clinics served approximately 35,000 women ages 19 years of age and older and Title XIX served 2,350 reproductive health clients 19 years of age and older (adjusted for limited duration of benefits), for a total served of 37,350 WIN who received public funded reproductive health services. This means that less than one-third (30%) of women ages 19 and older who need reproductive health services in Oklahoma actually receive them.

Access Barriers

Women in need of reproductive health services may face a variety of barriers when attempting to access services. These include: previous limitations on increases in federal monies[8] for reproductive health services; the increasing costs of both delivering services and conducting

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[5] 1997 PRAMS.

[6] Derived from information obtained from the Alan Guttmacher Institute, 1999 and US Census 2000.

[7] Kaiser Family Foundation: Health Coverage and Uninsured, 1997-1999.

[8] Due to passage of recent legislation, future reproductive health funding levels may increase.

outreach activities; and, limited clinic hours of operation and locations of reproductive health facilities.

- At the organizational level, barriers include limited numbers of providers, inadequate funding, and limited clinic availability. For example, in rural areas access is limited by the number of available providers, and services are available only on certain days of the week or month.
- An added inconvenience is that in some areas of the state, the average waiting time for an appointment is over 30 days, compared to a statewide average waiting time of 17 days.
- A third barrier faced by WIN is difficulty in finding transportation in rural areas and limited mass transit systems in urban areas.
- A fourth barrier relates to the need for bilingual providers or translation services for non-English speaking clients. Over the last few years, there has been an increase in non-English speaking clients seeking reproductive health services, while the number of births to Hispanic women in Oklahoma increased 75 percent during the period 1992-1998.[9]
- A final barrier relates to provider availability and willingness to serve the Medicaid population. Under the present reimbursement constraints, for example, physicians are refusing to provide sterilizations and selected reproductive health methods.

Less than one-third of women who need publicly funded reproductive health services actually receive them and access to these services is restricted even when services are sought. Therefore, it is not surprising that low-income women in Oklahoma continue to experience unintended births, or that Medicaid subsidizes the majority of these births.

Couples in need of reproductive health services face additional barriers in attempting to access services. The majority of reproductive health service providers tailor their services, waiting areas, and advertising to female clients only. Contraceptive counseling is currently provided to the woman alone, placing the responsibility on her to decide the preferred method without input or the ability to obtain support and confirmation from her partner. This process further erodes male responsibility for decision-making by ensuring that the male receives contraceptive information second-hand, which further devalues his participation.

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[9] Oklahoma Vital Record 1992; 1998.

CHAPTER III: THE PROPOSED DEMONSTRATION WAIVER

COVERED POPULATIONS

Oklahoma intends to expand Title XIX comprehensive reproductive health and health care benefits that will be available to two distinct groups of individuals, ages 19 and older:

- Uninsured women regardless of pregnancy history, whose family income is at-or-below 185 percent FPL, who are not otherwise eligible for Medicaid benefits, including women who gain eligibility for Title XIX reproductive health services due to a pregnancy, but whose eligibility ends 60 days postpartum;
- Men and couples at-or-below 185 percent FPL, regardless of pregnancy or paternity history.

Eligible individuals under 19 years of age[10] are covered under the State Children Health Insurance Plan. Currently, these clients can access reproductive health services under Medicaid at the provider of their choice.

For all groups, reproductive health Medicaid eligibility will remain in effect for one year. Participants will recertify for Medicaid eligibility annually. Loss of eligibility will occur when a participant moves out of state, becomes pregnant or otherwise Medicaid-eligible, or requests closure.

Conceptual Outline of the Reproductive Health Research and Demonstration Waiver

The expansion of comprehensive reproductive health services for women and men in Oklahoma will be developed and implemented through a collaborative interagency effort and agreement between the Oklahoma Health Care Authority, the Oklahoma State Department of Health, the Oklahoma Department of Human Services, and the Oklahoma State Medical Association. Prior to implementation of the proposed expansion, program standards and requirements will be developed and approved in an "Implementation Protocol." Also included in the "Implementation Protocol" will be a comprehensive education curriculum and outreach component.

[10] Currently, children 17 and under are covered by SCHIP, however eligible ages are expected to included 18 year olds later this year.

Authorized providers under the expanded program will include independent and FQHC public health clinics certified under Title XIX; OSDH County Health Department clinics, private physicians and practice management groups, tribal governments, Indian Health Service, and urban Indian providers. Physician Assistants (PAs) and Advance Nurse Practitioners (ANPs) may provide services within the scope of applicable Federal and/or State statutes and accepted PA and APN practice standards. Participating providers will be required to deliver a comprehensive reproductive health benefit, as outlined below.

Reproductive Health Benefits Package

The comprehensive reproductive health benefits package will include a comprehensive set of benefits, plus an enhanced package containing outreach and educational services. The comprehensive benefit portion will be funded through Title XIX funds, while the enhanced benefit portion will be funded through Title X funds.

Comprehensive Services

Comprehensive services will include:

- Comprehensive health assessment. This will be documented in the data collection system.
- Risk Assessment for unintended pregnancy, poor pregnancy outcome, sexually transmitted diseases or the need for family support services. The Risk Assessment will identify those at risk and in need of expanded outreach, case management, and/or educational services.
- Preconceptual Counseling. Preconceptual Care and Counseling: Information and counseling targeted at improving maternal health and reducing health risks for pregnancy.
- Health Promotion: Information will be available, as needed, on infertility, nutritional assessment, weight control, anemia, metabolic defects, parent/child communication, human sexuality, emotional problems, planning pregnancies, and genetics. Providers will also offer information on health maintenance services, such as screening, immunization, and general health education and counseling directed toward health promotion and disease prevention.
- Cancer screening and prevention: All female clients will receive instructions for breast self-examinations and male clients will receive instructions for testicular self-examinations. Female clients will also receive an annual Pap smear to screen for cervical cancer. Clients with abnormal Pap smear results will be referred to the appropriate provider.
- Pregnancy Diagnosis and Counseling. A pregnancy test will be administered when indicated. Clients who are diagnosed as pregnant will be provided information and counseling for their pregnancy, and if they desire, will be referred for appropriate obstetrical and gynecological services. Clients who are found not to be pregnant, will be given information about the

availability of contraceptive and infertility services and offered immediate supplies of an appropriate contraceptive method, upon request. All testing is conducted in accordance with federal law and standards.

- Education and Counseling services specific to reproductive health. Each new client will be instructed on the reasons reproductive health is important for the maintenance of individual and family health. They will receive basic information concerning female and male reproductive anatomy and physiology and all available methods of contraception. A risk assessment will be performed and client-centered, appropriate discussions will occur related to identified risks for STDs, including HIV. Informed Consent. Each client will be asked to sign consent for treatment, including a specific consent for each contraceptive method prescribed. Providers will be required to comply with all procedures and regulations as outlined in the federal regulations, "Sterilization of Persons Federally Assisted Reproductive health Projects (42 CFR 50.204-205)."
- Client History. Each new client will be asked to provide a complete personal, sexual and reproductive health history, and medical history of the immediate family. This will be evaluated to enhance a decision regarding the most medically appropriate contraceptive method, evaluate high-risk medical conditions, treatment options and referral for more comprehensive medical follow-up.
- Physical Examination. Each client will be provided a complete physical examination, annually, including evaluation of weight, blood pressure, head, neck and back, extremities, breasts, and abdomen. Female clients will receive a pelvic and breast examination. Male clients will receive examination of genitals and rectum including palpation of the prostate, if indicated.
- Laboratory Tests. Routinely will include a Pap smear, hemoglobin, and/or hematocrit. Rubella screening, a test for gonorrhea/chlamydia, HIV/AIDS, serologic test for syphilis, and/or screening for other STDs, if indicated.
- Contraceptive Method Information and Client Counseling. Method specific counseling will be provided after the physical examination to assure that the client is informed of the results of the history, physical examination, and laboratory tests that may have a bearing on the choice of contraceptive method. The client will be counseled on how to use the method, the common side effects, possible complications of the method selected, and what to do should they occur. A scheduled date of return will be provided as needed. The client will be given an emergency 24-hour telephone number and location of emergency services in case any complications should arise. Whenever possible, a reminder phone call will be made prior to the appointment.

- Contraceptive Supplies. All temporary and permanent methods approved by the Federal Food and Drug Administration (FDA) will be made available by all providers or through referrals.
- Subsequent Visits. Following the initial visit, all clients will be scheduled a return visit for method follow-up according to medically sound protocol. Clients will be told of the need for subsequent medical evaluation visits related to the chosen method, should problems with the method arise. Clients should be informed of the process for obtaining continued contraceptive supplies.
- Follow-up. Clients whose Pap smears are abnormal and/or whose screening for STDs show abnormal conditions will receive follow-up services and a referral, if needed.
- Psychosocial Screening. Clients will be screened for psychosocial needs, including depression, substance abuse, family violence, and/or other needs. Referrals will be made to the appropriate resources.
- Referral. When indicated, clients will be provided referrals to other health care providers, based on clinical findings from counseling, risk assessment, physical examination, and/or laboratory tests. The provision of services is not the responsibility of Title XIX or Title X.
- Sterilizations. Examination and services for vasectomies and tubal ligations restricted to persons age 21 years and over.

Enhanced Services

Enhanced Services will have five major areas of focus, each intended to increase client access and utilization of services. These are:

- Client Survey. Upon application for services, client(s) will complete a personal history, including questions regarding intended/desired fertility, and the client's current goal and future goal regarding family size. This will require follow-up survey questions designed to determine whether goals were reached through the provision of reproductive health services.
- Client Information and Education. A variety of channels will be utilized to ensure the provision of one-on-one reproductive health client education and a brief explanation of location and type of services available, with a referral to the most convenient location. Each new client will also receive written reproductive health information and a directory of service locations. Statewide reproductive health training will be offered through the OSDH Women's Health Service to counselors in communities, including school systems, church groups, family resource groups, and others. Training will be offered to school-linked staff to provide courses in human growth and development. Other educational services will be offered to health care providers through medical schools, schools of nursing, and other allied

health professional education settings. Culturally and linguistically appropriate posters and flyers explaining where services are located and what the services include will be placed in local communities at grocery stores, pharmacies, laundromats, restaurants, low income housing complexes, convenience stores, etc.

- Outreach. Outreach programs are necessary to reach and recruit prospective clients for reproductive health services, particularly those clients who typically face access barriers. Outreach will be coupled with educational activities and targeted toward high-risk and hard-to-reach populations. In addition, for the demonstration project to be successful, it is critical that culturally sensitive outreach strategies be employed. In order for the demonstration project to meet its objectives, clients must be made aware of the extension of Medicaid reproductive health coverage, the value of the services and the importance of accessing the services. There will be three major components of targeted outreach. These include: 1) enhancement of current outreach efforts; 2) statewide media campaign; and 3) provider outreach activities. These will be addressed in more detail in the subsequent section entitled, "Marketing and Outreach."
- Case Management. Individuals who experience stress or frequent disruption in their lives are less likely to prevent unintended pregnancies and be successful in extending the period between pregnancies. Professional case management services and care coordination are essential in providing support and advocacy to clients who desire services and are attempting to maneuver through the health care system. Particularly for women who are postpartum, case management will provide psychosocial and social service support after delivery. Such services will maximize the prospects for women after delivery to obtain reproductive health services on a consistent and routine basis.
- Referral. Reproductive health providers will provide clients with referrals for additional non-reproductive health related services. These could include, but are not limited to, referrals for home visitation, case management, nutrition counseling, social services, mental health, substance abuse treatment, WIC, immunizations, genetic counseling, well child care, abnormal pap smear evaluation, breast lump evaluation, HIV/AIDS testing, and treatment and/or evaluation of other identified medical problems. Further medical evaluation and care is not the responsibility of Title XIX or Title X.

Reproductive health providers will collaborate and network closely with other public health and social service programs such as TANF, WIC, Chronic Disease services, Maternity services, Congenital Defects services, ODHS, Healthy Start, Child Welfare, tribal governments, Indian Health Service, and urban Indian providers to assure referrals for reproductive health services.

Reproductive health providers will utilize existing programs such as Children First and Healthy Families to reach the targeted population and facilitate use of services. Children First is a state-wide nurse home visit program serving high-risk first time mothers, beginning no later than the 28th week of pregnancy and following the family until the child is 2 years old. Children First is statewide, serving over 5,000 families. Healthy Families is a model program designed to reduce infant mortality in high-risk populations. This state and federally funded program involves case management, home visitation and outreach to reduce risk factors, including emphasis on spacing of children to reduce infant mortality.

Male and Couple Involvement

Recent research indicates that there is an increasing interest by males in the involvement with partners regarding the selection and use of birth control. According to a technical report published by the United Nations Population Fund, several factors account for a changing climate for male-involvement initiatives in reproductive health.[11]

- The advent of the AIDS epidemic has spurred intense interest in condom promotion;
- Men are more favorable to the principle of reproductive health than had been assumed;
- Male support affects both adoption and the correct use of female contraceptives;
- The body of knowledge regarding male-involvement programs is growing and improving. Reproductive health agencies are finding that male-involvement programs can be cost-effective if they are highly focused and offer male contraceptive methods directly or by referral;
- The role of males in the abuse of reproductive rights and sexual violence directed towards female partners can't be ignored;
- The international consensus has created a momentum for action.

In addition, the argument has been made that in the zeal to liberate and empower women, advocates of women's development programs have reinforced gender discrimination by excluding men. "Solutions to problems relating to female poverty, unwanted pregnancy, and domestic violence, for example, have focused on women exclusively, in the assumption that men are unaware, indifferent or unwilling to help," states Nick Danforth, a longtime advocate of

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[11] Green, Cynthia, Sylvie Cohen, and Hedia Balhadj-Ej Ghouayel, *Male Involvement in Reproductive Health, Including Reproductive Health and Sexual Health*. Technical Report No. 28. New York: United Nations Population Fund, 1995.

involving men in family health and reproductive health. "Studies revealing gender gaps in health, education, training, workloads, and earnings are necessary steps in finding remedies." He states further "in one area that profoundly affects couples and families – reproductive health, including family planning – the exclusion of men has been blatant. Most men are very interested in family planning and in preventing sexually transmitted diseases (STDs). Most men are also concerned about ensuring safe motherhood for their wives and the survival and well being of their children."[12]

According to evidence from recent field experience, an impact can be made on both male and female behavior-related reproductive health by employing well-targeted male-involvement programs. Anticipated changes include more responsible sexual behavior, increased contraceptive use, and greater communication between partners. [13]

Frequently, barriers occur which discourage men from becoming more involved in the reproductive health of their partners. Moreover, reproductive health services for men are not often provided. One study indicated that common barriers for men seeking health care include:[14]

- The common perception that reproductive health clinics are female organizations that serve women, only. This is fostered by an overwhelming number of female clients.
- Men, in contrast to women, are not very familiar with the health care system or with their medical needs.
- Many clinics report having no funding available for men or for services they seek, such as vasectomies, which are particularly under funded.
- Men are much less likely, themselves, to be eligible for Medicaid because the program is so closely tied to TANF.

For effective family planning to occur, males must be involved in the process. This requires involvement in making decisions regarding methods of contraception, which includes but is *not* limited to vasectomies. Clinics have a responsibility to involve partners whenever possible by

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[12] Burdett, Harold N., *Toward the 21st Century*, The Population Institute, 1996.

[13] Ibid.

[14] Schulte, Margaret M., and Freya L. Sonenstein, *Men At Reproductive Health Clinics: The New Patients?,* Reproductive Health Perspectives, Volume 27, Number 5, September/October 1995.

creating an open and inviting environment that is friendly to both partners. Ideally, this would include male health services, male counselors for reproductive health issues, and a general attitude that is accepting of males who accompany their partners to gynecologic exams and reproductive health appointments.

The State of Oklahoma proposes the establishment of at least two sites, one urban and one rural, to identify effective methods for increasing male participation in reproductive health services. One site has already offered to take part in this activity – Planned Parenthood of Arkansas and Eastern Oklahoma, Inc. with administrative offices in Tulsa, Oklahoma. A rural area will be selected which has enough clinic patient flow to access data and will represent the state with appropriate diversity. Comprehensive services will be provided, including clinical as well as educational services. Pre and post exam counseling, where contraceptive methods are discussed, will include both partners, when appropriate.

Outreach efforts will be used to seek couples who desire services. Initially, focus groups will be held to determine the most effective strategies for marketing this service to clients. All couples will be provided services in a focused manner, accommodating the needs of both partners.

Men will be encouraged to participate in reproductive health clinics as individuals. Men will be eligible to enroll for and receive a comprehensive exam, health promotion, contraceptive counseling, and STD/HIV prevention and treatment.

EVALUATION

Evaluation of the couples component of the demonstration project will use several methods. The project will use administrative data to show the effectiveness of the project when compared to a matched control group, drawn from clinics that do not offer couples counseling. Administrative data will be used to evaluate no-show rates. Surveys of couples will be administered before services are rendered to gather baseline data. All couples served will complete a satisfaction survey of services to determine if clients are more satisfied with the couple services. Male focus groups and questionnaires may be developed to gather information about male attitudes and perceptions of reproductive health services and clinics.

MARKETING AND OUTREACH

Enhanced marketing and outreach will be employed to increase utilization by currently covered populations as well as to assure utilization by females and males in the newly covered populations. The OHCA, OSDH, OSMA, and ODHS will develop standards for these efforts. The marketing and outreach plans contain the following major components:

- Expansion and Enhancement of Current Outreach Efforts. An eye-catching notice will be sent to clients whose existing postpartum Medicaid benefits have been terminated informing them of their eligibility for Medicaid reproductive health services. The notice will present brief, summary information of core reproductive health services, available contraceptive methods, and a toll-free information number to call for questions and enrollment. Newly developed notices and "stuffers" will be mailed periodically to existing Medicaid clients reminding them of the benefits and availability of reproductive health services. Brochures and pamphlets will be developed and distributed through ODHS local offices, reproductive health clinics, day care sites, beauty salons, home visitation programs, hospital discharge packets, WIC, OB/Gyn physicians, and other women's health providers and clinics. Information also will be distributed to all applicable TANF recipients.
- Statewide Public Awareness Campaign. The OHCA, OSDH, OSMA, and ODHS will build upon current media experience and success experienced through the OHCA ***SoonerCare*** Program. They will develop standards and implement a joint enhanced public awareness campaign that will include a logo and slogan for the demonstration project, including the male involvement project, a toll-free information number for questions, public service announcements, and a poster campaign. Prior to public release, the OHCA, ODHS, OSDH, and OSMA Public Relations Departments will approve all campaign products. Information Line staff will be trained and skilled in answering questions and addressing concerns expressed by clients. Information Line staff will also provide information regarding the nearest and/or other accessible reproductive health providers. They will be trained and knowledgeable about reproductive health program policy in order to field such questions from clients, as well as those asked by the general public. Information Line staff will be trained to handle concerns of parents and others desiring to express their opinions. During non-business hours, callers will be connected to a computerized, interactive telephone reproductive health information line. Public Service Announcements (PSAs) will inform the public of the overall project, engender a positive image of the effort, explain how to access the services, and refer the viewer or listener to a contact source if they have questions. The

announcements will target high-risk populations in need of reproductive health services and will include multiple forms of media: radio, movie theater advertisements, billboards, and television. Whenever possible, these will be aired during prime-time(s), in order to ensure they reach a substantial portion of the population. Grant funding may be sought for a portion of this project. Focus groups will be conducted to determine the most effective means of reaching target populations.

- Client Outreach. The project will collaborate with existing outreach programs in the metropolitan areas of the state. Both Oklahoma City and Tulsa have Healthy Start grant projects that include outreach components. Whenever possible, other rural outreach programs will be identified in order to recruit clients and inform them of reproductive health services.
- Provider Outreach Activities. Existing and new providers will be invited to submit bids for additional funding for outreach activities above the provision of basic and expanded reproductive health services. The purpose of this new outreach will be that reproductive health providers will offer face-to-face follow-up with each individual client after the client is terminated from regular Medicaid benefits, identified as a prospective client in the demonstration project and/or to facilitate presumptive eligibility for specific clients. The outreach will be used to emphasize and underscore the benefits to the client for accessing expanded Reproductive health benefits offered through the demonstration project. Provider staff may employ a variety of methods to contact clients. To follow up, providers may call or write clients in order to set up a face-to-face home or office visit. All of these outreach strategies will be conducted in a culturally sensitive manner; will respect client confidentiality; and will not be intrusive. They will be required to submit quarterly reports on the number of client and phone contacts, referrals, home visits, and other activities.
- Provider Training. Expertise in the delivery of services for new providers, training on culturally sensitive counseling, client recruitment and outreach, information line staff training, etc, may be provided, as needed.

Provider Base Support

The Medicaid clients are assured freedom to select any Medicaid reproductive health provider from among all approved provider types. These include OSDH County Health Department clinics, independent community clinics, physicians, managed care organizations, advanced practice nurses, physician assistants, federally qualified health centers, tribal health care providers, and rural health clinics.

Upon certification as a Medicaid provider by the OHCA, each provider type listed above will be eligible to bill for Oklahoma Medicaid reproductive health services within their scope of practice. Providers will receive information about reproductive health services through the Medicaid Provider Procedures Manual and provider workshops and training. Technical assistance will be available upon request from any provider.

Enrollment

Women who are not currently certified as Medicaid eligible and who desire to apply for reproductive health benefits under the project, may apply at local Department of Human Services offices or County Health Departments. These providers will have available an abbreviated application form for Medicaid benefits, under this defined project. All potential participants will be required to declare their personal income and resources and the standard income applied will be 185 percent of FPL. No assets tests will be utilized. Other eligibility requirements will include citizenship, Oklahoma residency, and Social Security number.

Any participant desiring reproductive health services will be allowed to receive such services immediately under "presumed eligibility determination" (PE) if authorized. A one-page worksheet will be utilized to facilitate an efficient enrollment process, so those clients receive a contraceptive method to prevent an unintended pregnancy as rapidly as possible. Current PE providers will submit the worksheet and form SC1 (**SoonerCare 1**) to DHS for eligibility determination. Public health providers will receive reimbursement for the PE process. All providers will receive reimbursement for services provided during the PE period (not to exceed 45 days) of time. Enrollment will occur continuously throughout the duration of the project. All participants will have an annual eligibility redetermination.

Loss of eligibility under this 1115(a) waiver will occur when the participant moves outside the State of Oklahoma, becomes pregnant or eligible under another Medicaid category, voluntarily withdraws from the project, dies, becomes institutionalized, or obtains private insurance that includes contraceptive coverage. If the recipient is sterilized, she/he will be eligible for one limited annual medical visit.

CHAPTER IV: RESEARCH DESIGN

The proposed outcome of this waiver is the prevention of unintended pregnancies to women ages 19 years and older who are at or below 185 percent of the FPL, thereby reducing Medicaid expenditures for prenatal, delivery, and infant care in this population. As shown in the Logic Model (Figure 4.1), the evaluation will focus on process activities (the actual implementation of expanded reproductive health services, inputs, efforts, conditions), first and second level outcomes (short-term or proximal goals), impact (long-term or distal goals), and cost/benefit analysis including budget neutrality.

The evaluation will be conducted by research professionals external to OHCA, OSDH, OSMA, and/or ODHS. OHCA will contract directly with either a local university or a private and/or non-profit agency through the approved Invitation to Bid process, which will adhere to federal and state policies and regulations. Both the University of Oklahoma and Oklahoma State University, for example have professional research facilities equipped with phone banks and technical research staff.

DATA SOURCES

Both primary data and administrative records will be available, as necessary, for the project evaluation. Data sources include: client and service provider surveys, birth records (OSDH), past and future PRAMS surveys (OSDH), Medicaid paid claims (OHCA), Medicaid eligibility records (ODHS), and Reproductive health Services data (OSDH). All data will be collected for one year before the implementation of the waiver and related policy changes in order to establish baseline measures.

The OHCA and the OSDH jointly will assemble much of the data necessary for analysis of the project. In addition, the OHCA will provide historical data for the comparison group in this evaluation. The OSDH and the OHCA project lead staff will work closely with the contracted evaluation team.

HYPOTHESES

The major research hypotheses are listed below along with the corresponding project goals and objectives. The project is expected to produce positive results for Oklahoma and the hypotheses are worded as one-tail tests.

Goal 1:	Reduce the number of unintended pregnancies resulting in live births for women who are at or below 185 percent of the Federal Poverty Level through the provision of expanded Reproductive health services.
Hypothesis 1:	The proportion of births reported to be mistimed or not wanted for women who are at or below 185 percent of the FPL will decline.
Data Resource:	The number of women with household incomes at or below 185 percent of the FPL who report that their most recent pregnancy and live birth occurred sooner than they wanted or that the pregnancy and resulting live birth was not wanted at all. **Data Required:** PRAMS surveillance data. **Source:** OSDH.
Goal 2:	To assist women and/or families in reaching their desired level of fertility.
Hypothesis 2:	The proportion of women or couples in ***SoonerPlan*** who experience unintended repeat Medicaid deliveries will decrease to a level consistent with the desired level of fertility of the participating women or couples.
Data Resource 2:	a) The proportion of women with an unintended Medicaid-funded birth who have a subsequent unintended Medicaid funded birth. **Source:** OHCA, PRAMS, and client intake surveys. b) The number of unintended Medicaid funded births by fiscal year. The number of participating women having an unintended Medicaid birth who have another unintended Medicaid funded birth within two fiscal years. **Source:** OHCA and PRAMS.
Goal 3:	To reduce the number of women who have subsequent mistimed or unwanted pregnancies and/or births.
Hypothesis 3:	Women who have received expanded reproductive health services will be significantly less likely to have subsequent mistimed or unwanted pregnancies and/or births than if they had not received expanded reproductive health services.
Data Resource 3:	The number of women who have received expanded reproductive health services that report subsequent pregnancies as being mistimed or unwanted. **Source:** Client intake and follow-up surveys.
Goal 4:	Participation of the spouse/partner in expanded reproductive health visits will result in a decreased number of subsequent pregnancies and/or births that are mistimed or unwanted.
Hypothesis 4:	Women who have received expanded reproductive health services with the support and participation of their spouse/partner will be significantly less likely to report that subsequent pregnancies/births were mistimed or unwanted.
Data Resource 4:	The number of women who have received expanded reproductive health services who report subsequent pregnancies as being mistimed or unwanted by level participation and support of spouse/partner in reproductive health services. **Source:** Client intake and follow-up surveys.

Goal 5:	To increase the number of women who were enrolled in ***SoonerCare*** for a delivery who will access reproductive health services funded by Medicaid within six months after the birth of their last child.
Hypothesis 5:	The proportion of women previously in ***SoonerCare*** who access reproductive health services funded by Medicaid within six months after the birth of their last child will increase.
Data Resource 5:	An unduplicated client count of Medicaid claims for reproductive health services for women who received a Medicaid-funded delivery within six months prior to a reproductive health service claim. Medicaid funded claims by service type, amount, client, and date of claim. **Source:** OHCA.
Goal 6:	Improve client access to reproductive health services through the use of a variety of public and private service providers.
Hypothesis 6:	The increased number, variety and geographic locations of reproductive health service providers who are eligible for Medicaid reimbursement will increase.
Data Resource 6:	The number, type and geographic location of Medicaid providers funded for reproductive health services. **Source**: OHCA
Goal 7:	To increase the number of clients from identified high-risk groups who receive reproductive health services, including men and women ages 19 and older at or below 185 percent of the FPL.
Hypothesis 7:	The expansion of Medicaid funded reproductive health services to men and women ages 19 and older who are at/or below 185 percent of the FPL will result in an absolute increase in the number of these individuals using reproductive health services.
Data Resource 7:	Unduplicated client count of funded claims for reproductive health services through Title XIX, Title X, or State general revenue by fiscal year. **Source**: OSDH, OHCA, and ODHS.
Goal 8:	Reduce Medicaid costs expended for pregnancy, prenatal, delivery, and infant care.
Hypothesis 8:	The demonstration waiver will produce a net annual savings in State and Federal Medicaid expenditures through the use of reproductive health services and the resulting reduction in costs for prenatal, birth related, and infant services.
Data Resource 8:	The estimated fiscal year Medicaid costs from births that have been prevented by the waiver less fiscal year Medicaid reproductive health expenditures for the waiver target population. Historical data on the number of women with Medicaid-funded births in order to develop statistical projections of births for the target population if they had not received reproductive health services. The number of women in the target population with Medicaid-funded births after waiver implementation including those receiving services from managed care providers. Associated prenatal, delivery, newborn and infant care Medicaid

expenditures for target population both pre and post-waiver implementation. **Source**: OHCA, OSDH, and ODHS.

ANALYSIS

Based on the nature of the data obtained and approval of the OHCA, the evaluation contractor will determine statistical methods of analysis. At a minimum, the statistical analysis will include descriptive statistics of pre-waiver and waiver populations, univariate analysis of change over time, hypothesis testing for each hypothesis identified, and multivariate analysis (i.e., multiple regression, ANOVA, and logistic regression). Analysis will be conducted with the entire population and for sub-groups based on race/ethnicity, age, and level of education. A significance level of $p = .05$, or better, will be used as the standard for failing to reject null hypotheses.

CHAPTER V: STAFF RESPONSIBILITIES AND DEMONSTRATION TIMEFRAME

Staff Responsibilities

During each phase of the proposed project, key OHCA, OSDH, ODHS, and Contract staff will have responsibility for the implementation, operation, analysis, and evaluation of the project. The following is an outline of the elements of responsibility during each phase:

Start Up Period

1. Develop interagency plans for eligibility determination, presumptive eligibility, claims processing, data collection, project research and evaluation.
2. Develop and submit Implementation Protocol.
3. Plan and host agency directors and other key staff meeting to introduce and discuss waiver project related issues and development of targeted outreach activities.
4. Begin development of education materials, standards, and design outreach activities.
5. Evaluate existing information databases and create modifications when indicated.
6. Begin development of media advertising, including the development of standards for materials and criteria for OHCA, OSDH, and ODHS approval.
7. Design enrollment and eligibility document.

Implementation Period

1. Determine eligibility.
2. Enroll eligibles.
3. Recruit providers.
4. Provide training and offer consultation on outreach and expansion of services.
5. Implement outreach efforts.
6. Hire and train information line staff.
7. Compile data and begin analysis.

Project Operation Period

1□ Continuation Application

2□ Evaluation

3□ Annual Report

Phase Out Period

1□ Prepare notification of termination of project.

2□ Continue data collection and analysis.

3□ Prepare formal analysis and report document.

CHAPTER 6: BUDGET NEUTRALITY

CASELOAD AND COST ESTIMATES

This chapter presents an analysis of Oklahoma's caseload and cost estimates for ***SoonerPlan,*** as well as for reproductive health and birth-related Medicaid services currently provided to individuals at or below 185 percent FPL. The following State fiscal years and types of data are included in the analysis:

FY 1997 - FY 1999	$\Rightarrow$	Actual historical
FY 2000 – FY 2001	$\Rightarrow$	Estimated current
FY 2002 - FY 2006	$\Rightarrow$	Projected

KEY ASSUMPTIONS

Since Oklahoma is placing an emphasis on male involvement, caseload and cost information is presented separately for females and males. Also, this analysis assumes that the number of eligible individuals who enter the project will receive the average benefit for the full year of eligibility, for each year that eligibility is maintained. The percent of cases converted and new cases opened take into account Arkansas' experience regarding caseload increases due to waiver expansion. The percent difference of Oklahoma WIN receiving reproductive health services under the present system compared to the increased number of WIN who would be served under the waiver expansion and costs associated under each assumption become the basis of the budget neutrality schedule.

Additional women receiving reproductive health services is assumed to translate to additional unintended births averted and to be cost-effective compared to birth-related costs. For example, when a woman in Oklahoma becomes pregnant and her family income falls at or below 185 percent of the FPL, she then becomes eligible for Medicaid, which covers the cost of her prenatal and delivery care. Giving low-income women the added option of receiving reproductive health services will prevent some of these unintended pregnancies, essentially averting these births. Furthermore, some estimates calculate that every public dollar spent on contraception saves three dollars that would otherwise have been spent on pregnancy-related and newborn medical care,

alone. This is considered a conservative estimate in that it does not account for welfare benefits and other publicly-funded social services often utilized by low-income women and families.[15]

PRIMARY DATA SOURCES

The OHCA maintains a Medicaid eligibility database that contains information regarding the number of eligible individuals and eligible months, as well as a separate database for total claims paid for medical care. Medicaid-reimbursed claims for prenatal care and delivery costs were extracted for FY 1998 and FY 2000 and average HMO capitation rates were used to calculate infant first-year-of-life costs and second year costs for developmentally disabled infants. Also, information obtained from the eligibility database was used to estimate the number of Medicaid-reimbursed births for FY 1994 - FY 1998.

Client Visit Records (CVRs) and Cost Center allocations maintained by the OSDH for FY 1997 - FY 2000 were analyzed and used to describe reproductive health caseloads and expenditures. The client and claims information obtained for both the Medicaid and the Reproductive Health Programs served as the foundation for the FY 2001 - FY 2006 projections. Projections are presented under two scenarios: first, under the current system, without the waiver (Table 3 and Table 4) and the second, with the waiver (Table 5 and Table 6). Each incorporates varying assumptions regarding the number of WIN who receive reproductive health services and the number of births, as well as associated costs.

In addition to primary data sources, the State relied on estimates of WIN of publicly-funded reproductive health services provided by the AGI; birth certificate data contained in State Vital Records; population estimates provided by the US Bureau of the Census; and medical inflation data contained in the Consumer Price Index, Bureau of Labor Statistics.

Caseload Estimates

Historic and Estimated Current Caseloads: Table 1:

Clients Receiving Title XIX Reproductive Health Services. To estimate how many women receive reproductive health benefits through Title XIX for waiver purposes, the yearly total

[15] Forrest, J.D., et al., 1996, p. 188.

indicated on the OHCA Medicaid Reproductive health Clinic/Physician Visits Report for FY 1997 – FY 1999 was adjusted (=Total*.90) to reflect clients ages 19 and older.[16] Further analysis (see Figure VI.1) indicated a steady decrease in the ratio of Title XIX reproductive health visits to Title XIX births during FY 1997 – FY 1999. Accordingly, for FY 2000 – FY 2001, Title XIX reproductive health estimates were constructed by applying a four percent annual decrease to this ratio (-.04), then applying the resulting factor to the estimated number of Title XIX births for that year, to arrive at the total Title XIX reproductive health caseload for that year.

Figure VI.1
Ratio of Title XIX Reproductive health Visits to Title XIX Births: Oklahoma FY 1997 – FY 2001

	FY 1997	FY 1998	FY 1999	FY 2000 (est)	FY 2001 (est)
Title XIX Reproductive health visits	17772	14171	15001	14392	13750
Title XIX Births	20279	18737	21150	21502	21858
Ratio of Reproductive health Visits to Births	.876	.756	.709	.669	.629

Clients Receiving OSDH Title X Reproductive Health Services. For OSDH Reproductive health clients, CVR records for State Fiscal Years 1997 – 2000 were analyzed to document the number of clients, females and males, meeting the following criteria:

- 19 years of age or older;
- at or below 185 percent FPL;
- clients receiving reproductive health services, other than, or in addition to, pregnancy testing.

The FY 2001 estimate for female clients was calculated by applying the average annual rate of change in three-year moving averages for the period FY 1997 - FY 2000 (-1.5%) to the FY 2000

[16] Since age-related information was not available for the number of Oklahoma women receiving Title XIX services, the estimated number of women receiving Title XIX reproductive health benefits who were ages 19 and older was calculated using the following rationale: 1) historically, approximately 90 percent of all Oklahoma births occur to women ages 19 and older; 2) reproductive health services currently covered by Title XIX presumably occur during the 60 day period following a Medicaid-reimbursed birth; 3) thus, a reasonable proximate is that 90 percent of the yearly totals (=Total*.90) indicated on the OHCA Medicaid Reproductive health Clinic/Physician Visits Report for FY 1997 – FY 1999 occurred among women ages 19 and older.

caseload. For males, the FY 2001 estimate used a somewhat different approach due to the variability of caseload size for male clients from year to year. That is, the Title X caseload for males first was calculated as a ratio of male clients to female clients for each year during the period FY 1997 – FY 2000 and then averaged. This average (0.075%) then was applied to the FY 2001 estimated number of females, to arrive at the estimated number of males for that year.

Percentage of WIN (ages 19 and older) served. For waiver purposes, this is a calculation of the number of Title X reproductive health clients added to estimated Title XIX reproductive health clients, where the Title XIX caseload has been adjusted (*.17) to reflect the limited duration of benefit coverage (see Figure VI.2). This total then is divided by the estimated number of Oklahoma women in need of publicly funded reproductive health services, for that year, who are ages 19 and older.

Figure VI.2

Estimated Number of WIN of Reproductive health Services Ages 19-44 at or below 185% FPL: Oklahoma FY 1997 – FY 2001

FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
119965	120043	121638	122744	123604

Source: Derived from information obtained from the Alan Guttmacher Institute (www.agi-usa.org)

Sterilizations. Information regarding the number of tubal ligations and vasectomies for FY 1997 – FY 1999 was extracted from a database monitoring contractual agreements for sterilizations funded through OSDH. Since the actual number of sterilizations performed each year varies according to the amount of funds appropriated, a flat estimate of 250 tubal ligations and 50 vasectomies is used for the purpose of the budget neutrality schedule.

Title XIX Medicaid Births. The OHCA report for estimated number of Managed Care deliveries for CY 1996 – CY 1998 was age-adjusted (=Total*.90) to reflect deliveries to women ages 19 and older and used as the basis for historical caseloads for FY 1997 – FY 1999. Estimates of Medicaid births for FY 2000 – FY 2001 were calculated by applying an annual growth factor of 1.66 percent to the FY 1999 estimate. The 1.66 percent increase represents the average annual rate of change in three-year moving averages for the period FY 1996 through FY 1999.

Caseload Projections: Scenario 1: Continuation of present trends, without waiver: Table 3:

Title XIX Reproductive Health Clients. The trend observed in the decreasing ratio of Title XIX reproductive health visits to Title XIX births during FY 1997 – FY 1999 is expected to continue to decline, although at the more moderate pace of two percent per year (-.02). This trend has been incorporated into the caseload projections for Title XIX reproductive health clients for FY 2002 – FY 2006. As with historical caseloads, this number was adjusted (*.17) to reflect the limited duration of benefit coverage, when calculating WIN served.

Title X Reproductive Health Clients. The number of Oklahoma women ages 19 and older who receive Title X reproductive health services is expected to decline by a modest one-half percent (0.5%) per year. This trend has been incorporated into the caseload projections for FY 2002 – FY 2006.

Percentage of WIN (ages 19 and older) served. This is a calculation of the total number of women in need of subsidized contraceptive services whose needs are met through publicly supported reproductive health services. The first component, total WIN, is based on population size, percent living in poverty, and percent with no insurance or Medicaid.

- *Population.* According to the Census Bureau, for the period 1995 – 2005, Oklahoma's overall population is projected to increase by a total of approximately 6.5 percent, or about 0.65 percent annually, while racial/ethnic minorities during this period are projected to increase by an average 19.8 percent, or about 2 percent annually.
- *Poverty.* According to the Census Bureau, since 1994, Oklahoma's overall poverty rate has maintained a moderate, yet steady decrease. This decrease, however, is not statistically significant and poverty rates among racial/ethnic minorities remain approximately two times higher compared to whites.
- *Uninsured.* According to Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999 and 1998 Current Population Surveys, 22 percent of non-elderly adult women in Oklahoma are uninsured and six percent receive Medicaid.

Accordingly, the number of WIN of publicly supported reproductive health services conservatively is projected to increase less than one percent (0.85%) annually for FY 2002 – FY 2006, specifically:

Figure VI.3

Projected Number of WIN of Reproductive health Services Ages 19-44 at or below 185% FPL: Oklahoma FY 2002 – FY 2006

FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
124654	125714	126782	127860	128947

Source: Derived from information obtained from the Alan Guttmacher Institute (www.agi-usa.org)

Thus, without waiver intervention, the decreasing trend in Oklahoma WIN who are served with publicly supported reproductive health services is projected to continue to decline.

Total Oklahoma Births. Examination of annual rates of change in three-year moving averages for total births in Oklahoma occurring 1990 – 1999, yielded an average annual growth rate of less than one-half percent (0.3%). This trend has been incorporated into the projections of total Oklahoma births for FY 2002 – FY 2006.

All Medicaid Births. Caseload projections for All Medicaid Births for FY 2002 – FY 2006 have been calculated by applying a 1.66 percent annual growth factor to the FY 1999 estimate and extending this value forward.

Projections: Scenario 2: Assumptions under waiver: Table 5:

Clients receiving Title XIX reproductive health services under waiver. This group includes 34,214 female and 386 male reproductive health clients converted from Title X; approximately one-half (13205/2) of clients converted from traditional Title XIX reproductive health services; and a total of 300 clients receiving sterilization services.

Percentage of WIN served. This calculation excludes the number of women who receive sterilization services each year and takes into account the base number of clients converted from Title X (34,214) each year, in addition to the following groups:

- Year 1: converts one-half of clients who typically utilize Title XIX reproductive health services (13205/2); and for the WIN served calculation, still counts a portion of remaining Title XIX reproductive health clients with partial coverage (13205/2)*.17) toward serving the number of women in need of public

reproductive health services.

- Year 2: converts remaining one-half of traditional Title XIX reproductive health service users to waiver services.
- Year 3 to Year 5: each year phases in 5000 additional women who become eligible for services under the waiver expansion.

Service Cost Estimates

Historic and Estimated Current Medical/Services Expenditures: Table 2:

Title X Reproductive health. Cost Center Allocations for Direct Services were analyzed separately, for females and males, to determine total and per client reproductive health costs for the period FY 1997 – FY 2001.

Medicaid pregnancy-related costs. Cost estimates for Medicaid-reimbursed births were derived from OHCA Capitation Rate Schedules for FY 1997 – FY 1999 for women ages 19 and for women ages 20 – 44. Blended averages were then multiplied by average tenure (FY 1997 = 8 months; FY 1998 = 8.74 months; FY 1999 = 8.44 months) to arrive at average expenditures per birth for prenatal care; delivery; and infants' first year of life. For FY 2000, pregnancy-related cost calculations and second year of life costs for disabled children were provided by OHCA. An 18 percent rate increase for Medicaid services was approved beginning FY 2001 and has been incorporated into cost projections.

Projected Medical/Services Expenditures Without Waiver: Table 4:

Economic inflation factors have not been incorporated into the cost projections in Table 4 and Table 6 for FY 2002 – FY 2006, since the budget neutrality schedule so closely follows rate increases for both the Medicaid program and OSDH-funded sterilizations. Accordingly, in Table 4, declines in total contraceptive-related expenditures are due to a continuation of present trends regarding decreasing utilization of publicly-funded reproductive health services, which also accounts for decreasing percentages of WIN served. Conversely, increases in total pregnancy-related expenditures are due entirely to the increasing number of Medicaid-reimbursed births.

Projected Medical/Services Expenditures With Waiver: Table 6:

In addition to the 18 percent increase for birth-related Medicaid costs, under waiver assumptions for FY 2002 – FY 2006, certain contraceptive-related costs reimbursed by Medicaid have been adjusted and projected forward to reflect the 18 percent rate increase and include:

- Basic reproductive health benefit for women: $ 192.34
- Basic reproductive health benefit for men: $ 82.60

As with projected service costs without the waiver, economic inflation has not been factored into the budget neutrality calculation for projected waiver expenditures in Table 6.

Under the waiver expansion, it is expected that increasing numbers of women will utilize publicly funded reproductive health services, thus increasing the percentage of WIN served, as well as increasing total contraceptive-related expenditures. Conversely, decreases in total pregnancy-related expenditures are due to the decreasing number of Medicaid-reimbursed births that would be expected by increasing the percentage of WIN who receive publicly supported reproductive health services. **For the purpose of the budget neutrality schedule, the percent difference in WIN served without the waiver, compared to WIN served with the waiver, is applied to the number of Medicaid-reimbursed births for that year among the target population** (see Figure VI.4).

Figure VI.4
Percent of Women in Need Served With and Without Waiver

	FY 2002	FY 2003	FY2004	FY2005	FY2006
% WIN served, without waiver	29.1	28.7	28.3	27.9	27.5
% WIN served, with waiver	33.6	37.7	41.3	44.9	48.4
Difference	4.5	9.0	13.1	17.0	20.9

Comparison of costs between Table 4, Projected Medical/Services Expenditures without the Waiver and Table 6, Projected Medical/Services Expenditures with the Waiver, demonstrates that the ***SoonerPlan*** program will be budget neutral in the second year of the project. Savings from averted births will continue to accrue through the end of the project period.

Administrative Costs Table 7

Administrative costs are expenditures incurred by the State and Federal government to oversee the Medicaid program. As reported on the HCFA-64 Financial Management Report for Oklahoma for FY 1998, Medicaid administrative costs for reproductive health equaled $107,598. Oklahoma's birth-related administrative costs in FY 1998 equaled approximately $6.2 million. This estimate was calculated by pro-rating Oklahoma's total administrative amount ($123.8 million) to reflect the five percent of Medicaid beneficiaries accounted for in that year by clients ages 19 and above receiving birth-related Medicaid benefits. For SFY 2002 through SFY 2006, the annual estimated administrative amount was pro-rated to four percent to reflect the shrinking size of this group relative to total Medicaid beneficiaries.

Initially, administrative costs under ***SoonerPlan*** are expected to exceed costs without the waiver due to new expenses associated with expanding eligibility. By Year 4, however, these added costs will subside and administrative expenditures will decrease, further enhancing budget neutrality.

CONCLUSION

The approval and implementation of this waiver will benefit the State of Oklahoma, the Federal government and, most importantly, the clients served. Net cost savings to the Medicaid program should accrue at both the State and Federal level due to the decrease of unintended pregnancies and the number of claims for conditions associated with unintended pregnancies, including treatment of miscarriages. Cost savings shown in the budget neutrality schedule have been conservatively projected for birth-related; first year infant medical; and second year disabled infant medical costs, only.

As reproductive health providers offer basic preventive health services and preconception counseling, subsequent pregnancies to reproductive health clients should be at lower risk for complication and adverse outcomes, including a decrease in elective abortions in the target population. Lastly, the increased availability of reproductive health services will help clients have planned and wanted pregnancies and improve the overall health and well-being of themselves and their families.

TABLE 1:
Historic & Estimated Current Caseloads at or below 185% FPL: SFY 1997 - SFY 2001
WIN Served at 185% FPL; Sterilizations; & Estimated Births

	SFY 1997		SFY 1998		SFY 1999		SFY 2000 (est)		SFY 2001 (est)	
Reproductive health Clients	# of Clients	% WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served
1 Women 19 and older (Title XIX)	17,015		13,568		14,363		13,816		13,205	
2 Women 19 and older (Title X)	36,039		35,219		35,231		34,735		34,214	
3 Men 19 and older (Title X)	326		176		309		164		257	
4 TOTAL TITLE X CLIENTS 19+ (2+3)	36,365		35,395		35,540		34,899		34,471	
5 TOTAL WOMEN SERVED 19+ (1+2)[1]	38,932	32.5%	37,526	31.3%	37,673	31.0%	37,084	30.2%	36,459	29.5%
Sterilizations										
6 Tubal Ligations	235		232		280		250		250	
7 Vasectomies	19		40		48		50		50	
8 TOTAL STERILIZATIONS (6+7)	254		272		328		300		300	
Oklahoma Births	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
9 Total Oklahoma Births	46,133	100%	48,160	100%	49,354	100%	48,470	100%	48,177	100%
10 VLBW	521	1.1%	592	1.2%	646	1.3%	597	1.2%	622	1.3%
11 Births to Women 19+	40,897	88.9%	42,747	89.1%	44,146	89.7%	43,573	90.1%	43,522	90.4%
12 Births 19+ $\leq$ 185% FPL (11 x 59.4%)	24,293	52.7%	25,392	52.7%	26,223	53.1%	25,882	53.4%	25,852	53.7%
13 All Medicaid Births	21,573	46.8%	19,933	41.4%	22,500	45.6%	22,874	47.2%	23,253	48.3%
14 To Women 19+ (13 x 90%)	19,416	42.1%	17,940	37.3%	20,250	41.0%	20,587	42.5%	20,928	43.4%
15 VLBW (14 x 10)	221	0.5%	222	0.5%	267	0.5%	255	0.5%	271	0.6%

1 NOTE: Title XIX WIN Served = number of clients x .17 since Title XIX Reproductive health coverage ends 60 days postpartum.

TABLE 2:
Historic & Estimated Current Medical Expenditures: SFY 1997 - SFY 2001
Reproductive health; Sterilizations; & Estimated Births

	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY2001 (est)	
Title X Reproductive health	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client
1 Women 19 and older	$7,005,261	$194	$7,549,193	$214	$8,334,245	$237	$8,753,220	$252	$8,810,789	$258
2 Men 19 and older	$20,613	$63	$12,081	$69	$22,245	$72	$12,054	$74	$19,316	$75
3 TOTAL/AVERAGE (1 & 2)	$7,025,874	$172	$7,561,273	$194	$8,356,490	$208	$8,765,274	$226	$8,830,105	$230
Sterilizations	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client
4 Tubal Ligations	$234,413	$998	$243,600	$1,050	$319,200	$1,140	$286,250	$1,145	$375,000	$1,500
5 Vasectomies	$3,718	$196	$8,240	$206	$8,784	$183	$10,300	$206	$15,000	$300
6 TOTALS (4 & 5)	$238,131	$938	$251,840	$926	$327,984	$1,000	$296,550	$989	$390,000	$1,300
7 Total/Avg Contraceptive Costs (3 & 6)	$7,264,005	$198	$7,813,113	$219	$8,684,474	$242	$9,061,824	$257	$9,200,789	$265
Title XIX Medicaid: Pregnancy-related	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth
8 Prenatal Care Costs	$20,032,846	$1,032	$20,709,398	$1,154	$18,065,835	$892	$19,009,313	$923	$22,802,533	$1,090
9 Delivery Costs	$40,697,489	$2,096	$39,634,663	$2,209	$47,509,133	$2,346	$51,278,100	$2,491	$61,510,406	$2,939
10 Infant Costs: 1st Year of Life	$56,850,048	$2,928	$53,279,647	$2,970	$61,473,735	$3,036	$68,591,767	$3,332	$82,278,934	$3,932
11 Disabled Infant Costs: 2nd Year of Life	$745,293	$3,388	$774,885	$3,506	$805,635	$3,629	$1,002,852	$3,756	$1,130,180	$4,432
12 Total Average Birth Costs (8+9+10+11) / Medicaid births to women 19 +	$118,325,677	$6,094	$114,398,592	$6,377	$127,854,337	$6,314	$139,882,031	$6,795	$167,722,053	$8,014
13 TOTAL/AVERAGE COSTS	$125,351,551	$6,293	$122,211,706	$6,596	$136,538,812	$6,556	$148,943,855	$7,052	$176,942,159	$8,279

TABLE 3:
Projected Caseloads Without Waiver: SFY 2002 - SFY 2006
WIN Served at 185% FPL; Sterilizations; & Estimated Births

	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006	
Reproductive health Clients	# of Clients	% of WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served
1 Women 19 and older (Title XIX)	13,143		12,924		12,694		12,453		12,200	
2 Women 19 and older (Title X)	34,043		33,873		33,703		33,535		33,367	
3 Men 19 and older (Title X)[1]	386		450		514		578		643	
4 Total Title X Clients	34,428		34,322		34,217		34,113		34,010	
5 TOTAL WIN Served	36,277	29.1%	36,070	28.7%	35,861	28.3%	35,652	27.9%	35,441	27.5%
Sterilizations										
6 Tubal Ligations	250		250		250		250		250	
7 Vasectomies	50		50		50		50		50	
8 TOTALS (6+7)	300		300		300		300		300	
Oklahoma Births	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
9 Total Oklahoma Births	48,322	100%	48,466	100%	48,612	100%	48,758	100%	48,904	100%
10 VLBW	665	1.4%	677	1.4%	689	1.4%	702	1.4%	714	1.5%
11 Births to Women 19+	43,828	90.7%	44,008	90.8%	44,188	90.9%	44,370	91.0%	44,552	91.1%
12 Births 19+ $\leq$ 185% FPL (11 x 59.4%)	26,034	53.9%	26,141	53.9%	26,248	54.0%	26,356	54.1%	26,464	54.1%
13 All Medicaid Births	23,639	48.9%	24,031	49.6%	24,430	50.3%	24,836	50.9%	25,248	51.6%
14 To Women 19+ (13 x 91%)	21,511	44.5%	21,869	45.1%	22,232	45.7%	22,601	46.4%	22,976	47.0%
15 VLBW (14 x 10)	296	0.6%	306	0.6%	315	0.7%	325	0.7%	336	0.7%

TABLE 4:
Projected Medical Expenditures Without Waiver: SFY 2002 - SFY 2006
Title X Reproductive health & Title XIX Medicaid

	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006	
Sterilizations & Title X Reproductive health	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client
Women 19 and older	$9,141,753	$267	$9,097,975	$267	$9,054,197	$267	$9,010,933	$267	$8,967,670	$267
Men 19 and older	$44,012	$101	$48,822	$98	$53,632	$95	$58,442	$93	$63,328	$91
Total/Avg Contraceptive Costs (1 & 2)	$9,185,765	$264	$9,146,797	$264	$9,107,829	$264	$9,069,376	$264	$9,030,998	$263
Title XIX Medicaid: Pregnancy-related	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth
Prenatal Care Costs	$23,437,740	$1,090	$23,827,806	$1,090	$24,223,320	$1,090	$24,625,372	$1,090	$25,033,960	$1,090
Delivery Costs	$63,223,841	$2,939	$64,276,053	$2,939	$65,342,960	$2,939	$66,427,503	$2,939	$67,529,681	$2,939
Infant Costs: 1st Year of Life	$84,570,927	$3,932	$85,978,411	$3,932	$87,405,553	$3,932	$88,856,284	$3,932	$90,330,604	$3,932
Disabled Infant Costs: 2nd Year of Life	$1,201,094	$4,432	$1,311,896	$4,432	$1,356,216	$4,432	$1,396,105	$4,432	$1,440,426	$4,432
Total/Avg Title XIX Costs	$172,433,601	$8,016	$175,394,166	$8,020	$178,328,050	$8,021	$181,305,263	$8,022	$184,334,670	$8,023

TABLE 5:
Projected Caseloads With Waiver: SFY 2002 - SFY 2006
WIN Served at 185% FPL & Estimated Births

	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006	
Reproductive health Clients & Sterilizations	# of Clients	% of WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served	# of Clients	% WIN Served
1 Women 19 and older	41,067	33.6%	47,669	37.7%	52,669	41.3%	57,669	44.9%	62,669	48.4%
2 Men 19 and older*	436		500		564		628		693	
3 TOTALS (1+2)	41,503		48,169		53,233		58,297		63,362	
Oklahoma Births	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
9 Total Oklahoma Births	47,354		46,498		45,989		45,277		44,102	
10 VLBW	652	1.4%	650	1.4%	652	1.4%	652	1.4%	644	1.5%
11 Births to Women 19+	42,950	90.7%	42,220	90.8%	41,804	90.9%	41,202	91.0%	40,177	91.1%
12 Births 19+ ≤ 185% FPL (11 x 59.4%)	25,512	53.9%	25,079	53.9%	24,831	54.0%	24,474	54.1%	23,865	54.1%
13 All Medicaid Births	22,671	47.9%	22,063	47.4%	21,807	47.4%	20,994	46.4%	20,446	46.4%
14 To Women 19+	20,543	43.4%	19,901	42.8%	19,320	42.0%	18,759	41.4%	18,174	41.2%
15 VLBW (14 x 10)	283	0.6%	278	0.6%	274	0.6%	270	0.6%	266	0.6%

*Note: Increase due to policy change to increase the number of males receiving FP services.

TABLE 6:
Projected Medical Expenditures With Waiver, Medicaid Only: SFY 2002 - SFY 2006
Reproductive health & Estimated Births

	SFY2002		SFY2003		SFY2004		SFY2005		SFY2006	
Medicaid: Reproductive health & Sterilizations	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client	Total Expenditures	Avg Expend per Client
1 Women 19 and older	$8,075,742	$197	$9,345,570	$196	$10,307,270	$196	$11,268,970	$195	$12,230,670	$195
2 Men 19 and older	$36,784	$84	$42,070	$84	$47,356	$84	$52,643	$84	$58,012	$84
3 TOTAL/ AVERAGE (1 & 2)	$8,112,525	$195	$9,387,640	$195	$10,354,627	$194	$11,321,613	$194	$12,288,682	$194
Medicaid: Pregnancy-related	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth	Total Expenditures	Avg Expend per Birth
4 Prenatal Care Costs	$22,383,037	$1,090	$21,683,533	$1,090	$21,050,492	$1,090	$20,439,244	$1,090	$19,801,845	$1,090
5 Delivery Costs	$60,378,753	$2,939	$58,491,825	$2,939	$56,784,185	$2,939	$55,135,327	$2,939	$53,415,930	$2,939
6 Infant Costs: 1st Year of Life	$80,765,215	$3,932	$78,241,180	$3,932	$75,956,966	$3,932	$73,751,384	$3,932	$71,451,444	$3,932
7 Disabled Infant Costs: 2nd Year of Life	$1,254,279	$4,432	$1,232,118	$4,432	$1,214,390	$4,432	$1,196,662	$4,432	$1,178,933	$4,432
8 Total Average Birth Costs (4+5+6+7)										
9 / Medicaid births to women 19 +	$164,781,284	$8,021	$159,648,655	$8,022	$155,006,034	$8,023	$150,522,616	$8,024	$145,848,153	$8,025
10 TOTAL/AVERAGE MEDICAID COSTS	$172,893,809	$2,787	$169,036,296	$2,483	$165,360,660	$2,279	$161,844,229	$2,100	$158,136,836	$1,939

TABLE 7:
Projected Medical Expenditures with Waiver, Medicaid Only: FY 2002 – 2006
Reproductive health and Estimated Births*

	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		
Medicaid Expenditures Under Waiver	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expend for 5 Years
Medical Expenditures	$172,893,809	$2,787	$169,036,296	$2,483	$165,360,660	$2,279	$161,844,229	$2,100	$158,136,836	$1,939	$827,271,830
Administrative	$5,347,076	$86	$5,002,031	$73	$4,859,305	$67	$4,720,978	$61	$4,627,379	$57	$24,556,769
Administrative: Birth-related	$4,519,460	$220	$4,378,220	$220	$4,250,400	$220	$4,126,980	$220	$3,998,280	$220	
Administrative: Reproductive health	$207,515	$5	$240,845	$5	$266,165	$5	$291,485	$5	$316,810	$5	
Includes Additional Administrative:											
a. Media Campaign	$50,000		$100,000		$50,000		----		----		
b. System Changes/Data Processing @ $.40/visit	$328,222		$32,755		$36,198		$39,642		$43,086		
c. Personnel	$75,000		$75,000		$75,000		$75,000		$75,000		
d. Client ID Cards @ $1.25 each	$51,879		$60,211		$66,541		$72,871		$79,203		
e. Helpline	$40,000		$40,000		$40,000		$40,000		$40,000		
f. Evaluation (contract)	$75,000		$75,000		$75,000		$75,000		$75,000		
SUB-TOTAL: Added Administrative	$620,101		$382,966		$342,740		$302,513		$312,289		
TOTAL	$178,240,885	$2,873	$174,038,327	$2,557	$170,219,965	$2,346	$166,565,207	$2,162	$162,764,215	$1,996	$851,828,599
Medicaid Expenditures Without Waiver											
Medical Expenditures	$172,433,601	$8,016	$175,394,166	$8,020	$178,328,050	$8,021	$181,305,263	$8,022	$184,334,670	$8,023	$891,795,750
Administrative	$4,732,420	$220	$4,811,180	$220	$4,891,040	$220	$4,972,220	$220	$5,054,720	$220	$24,461,580
TOTAL	$177,166,021	$8,236	$180,205,346	$8,240	$183,219,090	$8,241	$186,277,483	$8,242	$189,389,390	$8,243	$916,257,330
Difference: Waiver *minus* No Waiver	($1,074,864)	$5,363	$6,167,019	$5,683	$12,999,125	$5,895	$19,712,276	$6,080	$26,625,175	$6,247	$64,428,731
Total Federal Expenditures											
With Waiver	$125,403,765		$122,712,139		$120,262,090		$117,925,682		$115,477,982		$601,781,658
Without Waiver	$123,069,731		$125,181,506		$127,275,155		$129,399,794		$131,561,629		$636,487,815
Net Change	($2,334,034)		$2,469,367		$7,013,065		$11,474,112		$16,083,647		$34,706,157
Total State Expenditures											
With Waiver	$52,837,120		$51,326,187		$49,957,876		$48,639,525		$47,286,232		$250,046,940
Without Waiver	$54,096,290		$55,023,840		$55,943,935		$56,877,689		$57,827,761		$279,769,515
Net Change	$1,259,170		$3,697,653		$5,986,059		$8,238,164		$10,541,529		$29,722,575

Federal match rate for reproductive health service expenditures set equal to 90 percent; federal match rate for birth-related medical expenditures set equal to 70 percent; federal match rate for non-MMIS administrative expenditures set equal to 50 percent; federal match rate for MMIS-related administrative expenditures set equal to 75 percent.

*Assumes Waiver begins 2002; system change cost of $300,000; .40/visit process fee

	SFY2002		SFY2003		SFY2004		SFY2005		SFY2006		
Medicaid Expenditures Under Waiver	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expenditures	Expend per client	Total Expend for 5 Years
Medical Expenditures	$172,893,809	$2,787	$169,036,296	$2,483	$165,360,660	$2,279	$161,844,229	$2,100	$158,136,836	$1,939	$827,271,830
Administrative	$5,347,076	$86	$5,002,031	$73	$4,859,305	$67	$4,720,978	$61	$4,627,379	$57	$24,556,769
2 Administrative: Birth-related	$4,519,460	$220	$4,378,220	$220	$4,250,400	$220	$4,126,980	$220	$3,998,280	$220	
3 Administrative: Family Planning	$207,515	$5	$240,845	$5	$266,165	$5	$291,485	$5	$316,810	$5	
Includes Additional Administrative:											
a. Media Campaign	$50,000		$100,000		$50,000		----		----		
b. System Changes/Data Processing	$328,222		$32,755		$36,198		$39,642		$43,086		
c. Personnel	$75,000		$75,000		$75,000		$75,000		$75,000		
d. Client ID Cards @ $1.25 each	$51,879		$60,211		$66,541		$72,871		$79,203		
e. Helpline	$40,000		$40,000		$40,000		$40,000		$40,000		
f. Evaluation (contract)	$75,000		$75,000		$75,000		$75,000		$75,000		
4 SUB-TOTAL: Added Administrative	$620,101		$382,966		$342,740		$302,513		$312,289		
TOTAL	$178,240,885	$2,873	$174,038,327	$2,557	$170,219,965	$2,346	$166,565,207	$2,162	$162,764,215	$1,996	$851,828,599
Medicaid Expenditures Without Waiver											
Medical Expenditures	$172,433,601	$8,016	$175,394,166	$8,020	$178,328,050	$8,021	$181,305,263	$8,022	$184,334,670	$8,023	$891,795,750
Administrative	$4,732,420	$220	$4,811,180	$220	$4,891,040	$220	$4,972,220	$220	$5,054,720	$220	$24,461,580
TOTAL	$177,166,021	$8,236	$180,205,346	$8,240	$183,219,090	$8,241	$186,277,483	$8,242	$189,389,390	$8,243	$916,257,330
Difference: Waiver *minus* No Waiver	($1,074,864)	$5,363	$6,167,019	$5,683	$12,999,125	$5,895	$19,712,276	$6,080	$26,625,175	$6,247	$64,428,731
Total Federal Expenditures											
With Waiver	$125,403,765		$122,712,139		$120,262,090		$117,925,682		$115,477,982		$601,781,658
Without Waiver	$123,069,731		$125,181,506		$127,275,155		$129,399,794		$131,561,629		$636,487,815
Net Change	($2,334,034)		$2,469,367		$7,013,065		$11,474,112		$16,083,647		$34,706,157
Total State Expenditures											
With Waiver	$52,837,120		$51,326,187		$49,957,876		$48,639,525		$47,286,232		$250,046,940
Without Waiver	$54,096,290		$55,023,840		$55,943,935		$56,877,689		$57,827,761		$279,769,515
Net Change	$1,259,170		$3,697,653		$5,986,059		$8,238,164		$10,541,529		$29,722,575

Federal match rate for family planning service expenditures set equal to 90 percent; federal match rate for birth-related medical expenditures set equal to 70 percent;
federal match rate for non-MMIS administrative expenditures set equal to 50 percent; federal match rate for MMIS-related administrative expenditures set equal to 75 percent.
*Assumes Waiver begins 2002; system change cost of $300,000 & .40/visit process fee

Appendix A

EXHIBIT 1:

Population of Women Ages 19 – 44:
Oklahoma 1995 – 2000

Age:	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY2000
19	23691	24696	24679	25503	26671	26943
20-24	113771	112311	112416	114379	115435	119368
25-29	104366	106680	107887	108739	106990	112061
30-34	120066	114996	109703	105926	102671	110113
35-39	129106	129794	128941	128190	125195	129715
40-44	121750	125028	127951	130746	131150	133085
Total	612750	613505	611577	613483	608112	631285

Source: Files J:\1Paul\population\popest90-98.xls & statepopas99.xls compiled from information obtained from the U.S. Census Bureau (www.census.gov):

EXHIBIT 2:

Age-Specific Birth Rates for Women Ages 19-44:
Oklahoma 1995-2000

	CY 1995		CY 1996		CY 1997		CY 1998		CY 1999		CY 2000	
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
19	2666	112.5	2725	110.3	2880	116.7	2929	114.8	3028	113.5	2972	110.3
20-24	14604	128.4	14367	127.9	15203	135.2	15771	137.9	15540	134.6	15552	130.3
25-29	11752	112.6	12544	117.6	13050	121.0	13566	124.8	13195	123.3	13011	116.1
30-34	7792	64.9	7557	65.7	7741	70.6	7816	73.8	7766	75.6	7955	72.2
35-39	2912	22.6	3148	24.3	3227	25.0	3415	26.6	3394	27.1	3370	26.0
40-44	500	4.1	527	4.2	621	4.9	621	4.7	622	4.7	636	4.8
Total	40226	65.6	40868	66.6	42722	69.9	44118	71.9	43545	71.6	43496	68.9

Source: Oklahoma State Department of Health Vital Records

EXHIBIT 3:

Estimated Number of Title XIX Clients Receiving Reproductive health Services:
Oklahoma FY 1997 – FY 1999

	FY 1997	FY 1998	FY 1999
All Ages	18,906	15,075	15,959
Estimated 19 + (All Ages x 90%)	17,015	13,568	14,363

Source: Estimates derived from Oklahoma Health Care Authority Medicaid Reproductive health Clinic/Physician Visits Expenditure Report

EXHIBIT 4:

Percent Increase in Medical Inflation by State Fiscal Year

FY 1997	FY 1998	FY 1999	FY 2000 (est)	Avg Annual % Increase
2.9%	3.3%	3.3%	4.0%	3.4%

Source: Consumer Price Index, U.S. City Average, Medical Care Services: Bureau of Labor Statistics (www.bls.gov